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Look, then leap: quality and improving maternity care

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In maternity care, tolerance for risk is low and expectations for perfection are high. Reforming the status quo requires evidence.

Obstetricians have learned this lesson the hard way. A century ago, very little in obstetric practice was codified. Care was artisanal, variable, and sometimes dangerous. Based on a theory that childbirth is inherently 'pathogenic', prominent American obstetricians recommended sweeping reforms (DeLee. *Principles and Practice of Obstetrics*, 1913, 1st edn., WB Saunders Company, Philadelphia, Pennsylvania). Leaders exhorted their colleagues to mitigate the perils of childbirth by performing operative deliveries prophylactically—a leap that resulted in catastrophic suffering. Many became deathly ill from 'puerperal septicemia', and the US maternal mortality rate rose sharply in the first part of the 20th century (Woodbury. *Am J Public Health* 1924; 14:738-43). A passionate debate ensued about whether childbirth is truly pathogenic, requiring prophylaxis, or physiologic, requiring support. Proponents of the pathogenic view ultimately prevailed in designing the lasting and current system of care.

Thankfully, as infection control improved, so did maternal outcomes. Yet in many ways, the first part of the 21st century, appears strikingly anchored to the past. Care remains artisanal, variable, and sometimes dangerous. While the routine use of forceps and episiotomies advocated in the last century fell out of favour, another type of operative delivery—the caesarean—became increasingly common. Maternal mortality in the USA is once again rising sharply, driven at least partly by heedless intervention (Solheim et al. *J Matern Fetal Neonat Med* 2011;24:1341–6). Furthermore, the debate regarding the risks and limitations of prophylaxis in childbirth rages on, unsettled.

Last year, a global cohort of maternity care experts aimed to move past the counterproductive debate about whether pregnancy should be managed prophylactically by pointing out that mothers can be harmed in two ways: when we do too little, too late and when we do too much, too soon (Miller et al. *Lancet* 2016;388:2176–92). Right now, the UK is may be positioned to provide the world's most compelling case study on whether we can get the balance right.

Against the backdrop of avoidable maternal and infant deaths at the Morecambe Bay NHS Trust, the NHS maternity services across England, Scotland, and Wales launched the National Maternity and Perinatal Audit (NMPA). Much like astronomers looking through telescopes at the planets that patients and clinicians live on, auditors often get a global picture and must infer the details. Dr Greary and her fellow methodologists behind the NMPA have provided a blueprint for this telescope, accessibly explaining how they translated imperfect administrative data into robust and believable quality indicators. But even at low resolution, the emerging image of wide-scale variation in basic facets of care provide a compelling opportunity to identify and learn from pockets of excellence within the UK. The case for thoughtful reform is clear. Guided by evidence, I am hopeful this time we may get it right.

Disclosure of interests

Full disclosure of interests form available to view online as supporting information.